Patient Centered Medical Home Stakeholder Council
Meeting Minutes
March 19, 2013
CSI Conference Room, Helena, and by phone

Members present
Dr. Jonathan Griffin, Chair, St. Peter's Hospital
Dr. Janice Gomersall, Community Physicians Group, Mountain View Family Medicine and Obstetrics
Dr. Jay Larson, South Hills Internal Medicine
Carla Cobb, RiverStone Health
Todd Lovshin, PacificSource Health Plans
Dr. Monica Berner, Vice-Chair, Blue Cross Blue Shield Montana
Mary Noel, Medicaid Division, Department of Public Health & Human Services
Jane Smilie, Public Health and Safety Division, Department of Public Health & Human Services
S. Kevin Howlett, Tribal Health and Human Services, Confederated Salish & Kootenai Tribes
Lisa Wilson, Montana Family Link
Sen. Mary Caferro, State of Montana (Ad Hoc Member)

Members absent
Dr. Jeffrey Zavala, St. Vincent's Hospital
Dr. Joe Sofianek, Bozeman Deaconess Health Group
Paula Block, Montana Primary Care Association
Dr. Larry Severa, Billings Clinic
Dr. Thomas H. Roberts, Montana Health Co-op
Rep. Ron Ehli, State of Montana (Ad Hoc Member)
Richard Opper, MT Department of Public Health and Human Services (Ad Hoc Member)

CSI Staff Present
Amanda Eby– Minutes recorder
Christina Goe

Interested Parties
Patrick Van Wyk, St Peter's Hospital
Kim Van Wyk, Mountain-Pacific Quality Health
Stuart Doggart, MT Pharmacy Association
Dr. Gary Mihelish, NAMI Patient Advocate
Janice Mackensen, Mountain-Pacific Quality Health
Barbara Wirth, NASHP
Dr. Jonathan Weisul, Allegiance
Kelly Gallipeau, Kalispell Regional Health Center
Jody Haines, Providence Health System
Nick Honochick, Merck
Lois Steinbeck, Legislative Fiscal Division
Breann Streck, St. Vincents Physician Network
Starla Blank, Clinical Pharmacist at St. Peter's Hospital
Brie Oliver, public health nurse
Todd Harwell, Public Health and Safety Division, Department of Public Health & Human Services

Bill Warden, Hospital Lobbyist
Aidan Myhre, Pfizer

Welcome, introductions, agenda review, minutes approval

Carla Cobb moved and Todd Lovshin seconded a motion to approve the minutes. Minutes were approved unanimously.

Update on NASHP PCMH Learning Collaborative

Since their flights were cancelled for their previously scheduled trip here in February, Barbara Wirth and Mary Takach of NASHP have rescheduled their trip to Montana for April. They will be here April 14-17 for individual meetings with stakeholders. They will also give a presentation at the stakeholder council meeting on community care/health teams. Let Amanda know about questions or potential topics for NASHP.

Report from the Payer Subcommittee

At the last meeting, the subcommittee discussed the importance of or lack of importance of consistency in payment models. The pros would be ease of administration for providers. The cons would be limiting innovation for payers. There are some payers that may not necessarily have processes in place in Montana yet, but are exploring their options. Payers need provider input on how strongly providers feel about getting a standard uniform payment model or if it is more important to leave room for innovation. Kevin Howlett expressed concern about IHS's limitations on reimbursement rates based on CMS payment schedules. Dr. Griffin explained that there are many different models to consider. Amanda listed the various types of payment models being used in multi-payer states. Dr. Weisul commented that the commercial payers can lead the way since Medicaid does not have to follow the same payment rules.

Report from the Quality Measures Subcommittee

The subcommittee discussed the need to get moving and start collecting data to establish a baseline and show improvement before the 2015 legislative session. The subcommittee decided to have the reporting period be a calendar year so we have data from PCMHs to analyze before the 2015 legislature. DPHHS is working on specific protocols that could be used to collect the data. Public Health submitted draft rules for CSI to consider adding the rules for the MT PCMH program. CSI will be reviewing them and considering how to move forward. The draft rules on the quality measures will be up for discussion at the April meeting.

Christina Goe reviewed the rule making process and plan CSI had discussed for the rules on quality measure reporting. We could file rules by the end of April so they would have a late June effective date. We talked with the payer subcommittee to see if they wanted administrative rules on payment standards. If that subcommittee is not ready for payment standards by April, we will move forward with the quality measure standards first.

Medication Management Presentation by Carla Cobb from RiverStone Health

Medication management does not require any change in the scope of practice of pharmacists in Montana, this is already in their rules. The cost savings comes from a decrease in repeat hospitalizations and ER visits. The ROI is 12 to 1 in Minnesota, for every dollar spent on implementing comprehensive medication management. Many cost savings in a mental health pilot were based on stopping medications. It helps patients take back control of their health care. Since 2003, all pharmacists graduate with a PharmD. Older pharmacists that graduated longer ago might need additional training on the process of providing the service, this is very teachable. Everything else in comprehensive medication management in regard to the clinical aspect, pharmacists would be capable of providing. Medication management improves outcomes and reduces overall cost of care when it is integrated, comprehensive, consistent, coordinated, and communicated. Payment reform is essential.

Stuart Doggert said the Montana Pharmacy Association is very interested in supporting medication management in the Montana PCMH program. They want to be a partner in providing more Continuing Education (CE) so that pharmacists can provide this service to patients. Pharmacists are concerned about the criteria for patients to receive the service as far as how they will be identified. Pharmacists see this as a great opportunity if it can be a feasible business opportunity for pharmacies.

The legislature provided funding for pharmacists in the program Pharm Assist in 2007. Very few pharmacists signed up for it. Patients could go to a pharmacist and have their medications reviewed and that information would be transferred to the primary care provider. The limitations of that program would have to be considered to determine why more pharmacists didn't take advantage of it before asking the legislature for funding again. The program only paid pharmacists, not clinics and this was a large barrier. There was a huge conflict of interest for pharmacists working in the clinic not knowing where to meet the patient since the clinic wasn't getting paid. The community pharmacists' information isn't integrated in a clinic so there was no way to include those pharmacists. Without a medical chart in front of them in a community setting, it is much more difficult to make the appropriate decisions for the patient. Addressing how to integrate community pharmacists will be a major challenge and goal if medication management is added to the Montana PCMH Program.

Payers discussed how they could incorporate the medication management aspect of care coordination into a payment model. It's hard to know how to fund pharmacists in some of the smaller communities and make it financially viable. This is where community care teams and a multi-payer program comes in when payers pay on an attributed population basis. The program in Billings is easier to pay on blocks of time or other increments since it is a larger community. ICD-10 does have code for medication management but pharmacists are not reimbursed. It is difficult to determine the equity of the distribution of reimbursement when many patients are on Medicare and Medicaid and providers cannot pick and choose who they provide the services to based on their insurance.

Postpartum Depression Screening Presentation by Sen. Mary Caferro and Brie Oliver

Brie Oliver is a public health nurse that does home visits with mothers up to 5-years age of their child. Perinatal mood and anxiety disorder is the evolution of the term post-partum depression. It develops in

three stages rather than just post-partum. Research has found that often these disorders are going undiagnosed and untreated. Women experiencing depression within the post-partum period, if undetected within that first year, it goes on for several years after that and affects the way she is able to care for her children. It is the number one health issue related to child-bearing. This is an opportunity to help women with prior undiagnosed mental illness. Early detection can greatly reduce the duration and severity of symptoms for women. All health care professionals that have any contact with pregnant women should be doing the screening. Dr. Griffin said the Quality Metrics Subcommittee will consider how to incorporate this type of screening in PCMH measures. Dr. Van Wyk commented that providers may be reluctant to screen patients if they don't have the resources to intervene and take action if the screening is positive, such as medication management and behavioral health. Sen. Caferro passed out "Saving Moms: A Maternal Mortality Review Initiative" that was presented at the Children and Families Interim Committee. There is also a push for pediatricians to screen mothers at the well-child check-ups.

Public Comment

Dr. Mihelish - CMS proposed limitations under Medicare Part D to limit access to mental health medications. Due to pressure from outside sources they pulled back on those limitations. Last Thursday there was a hearing on the drug registry bill, it's not moving along very effectively. Mental Health Trust gave Carla money to do the study on comprehensive medication management. Dr. Mihelish listed off several other grants the Trust gave to clinics to do PCMH related activities. The Mental Health Trust will be announcing a new round of grants in June.

The meeting adjourned at 3:00pm.